

HOSPICE SERVICES PAYMENT SYSTEM

payment**basics**

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The Medicare hospice benefit covers a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician. Beneficiaries who elect the Medicare hospice benefit agree to forgo curative treatment for their terminal condition. For conditions unrelated to their terminal illness, Medicare continues to cover items and services outside of hospice. Typically, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities and other inpatient settings. Hospice providers can be freestanding entities or based in hospitals, skilled nursing facilities, or home health agencies.

CMS data show substantial growth in use of the hospice benefit among Medicare beneficiaries and associated program spending over the last 15 years. The share of Medicare decedents using hospice has increased from about 23 percent in 2000 to nearly 49 percent in 2015. About 1.38 million beneficiaries used hospice in 2015, compared with 0.53 million in 2000. The total number of providers has also increased. The number of hospice agencies participating in the Medicare program increased by 86 percent from 2000 to 2015, for a total of nearly 4,200 providers in 2015. In addition, as of 2015, about 65 percent of hospice agencies were for profit, compared to about 30 percent in 2000. Medicare payment for hospice grew from almost \$3 billion in 2000 to \$15.9 billion in 2015.

The hospice benefit and Medicare payment

The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. To provide this type

of care, the benefit covers an array of services, such as:

- skilled nursing services;
- drugs and biologicals for pain control and symptom management;
- physical, occupational, and speech therapy;
- counseling (dietary, spiritual, family bereavement, and other counseling services);
- home health aide and homemaker services;
- short-term inpatient care;
- inpatient respite care; and
- other services necessary for the palliation and management of the terminal illness.

Setting the payment rates

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit (Figure 1). Medicare makes a daily payment, regardless of the amount of services provided on a given day and on days when no services are provided. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans. Payments are made according to a fee schedule that has four different levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Table 1).

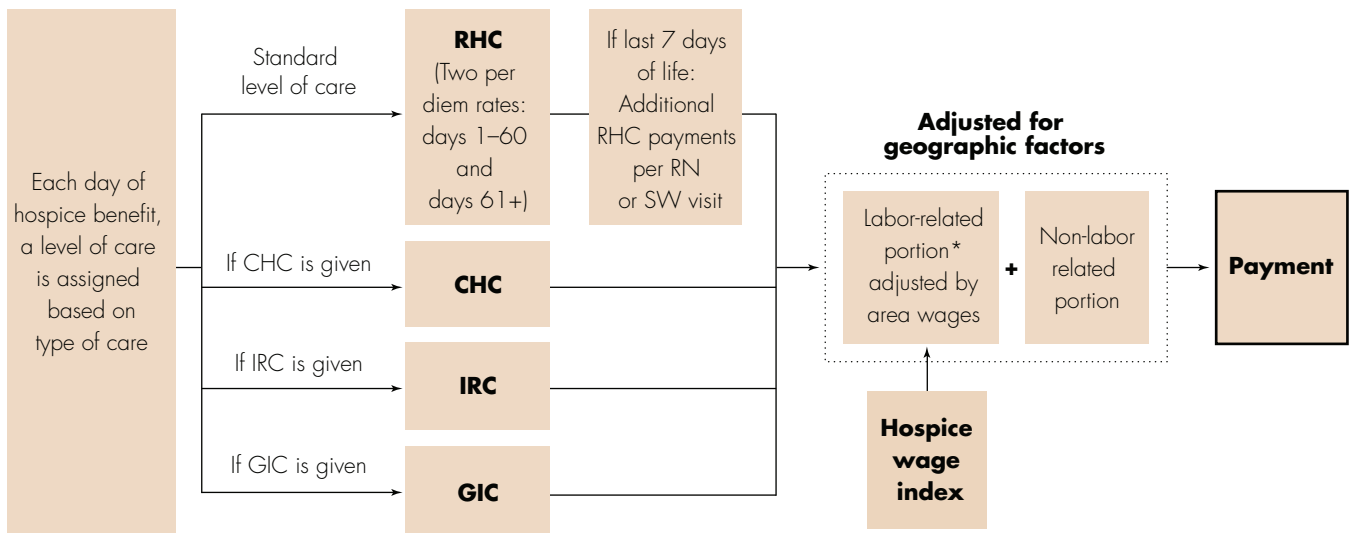
Hospice payment rates are updated annually by the hospital market basket. Beginning fiscal year 2013, the market basket index has been reduced by a productivity adjustment (as required by the Patient Protection and Affordable Care Act of 2010). An additional reduction to the market basket update of 0.3 percentage points has been required each year since 2013 and may be required again in 2019 (if certain criteria are met), after which

*This document does not
reflect proposed legislation
or regulatory actions.*

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Figure 1 Hospice prospective payment system



Note: RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care), RN (registered nurse), SW (social worker).
 *The labor-related portion adjusted by the wage index varies, depending on level of care (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

point the reduction sunsets. The Medicare Access and CHIP Reauthorization Act of 2015 specified the hospice update amount at 1 percent for fiscal year 2018. Beginning fiscal year 2014, hospices that do not report quality data receive a 2 percentage point reduction in their annual payment update.

The four levels of care are distinguished by the location and intensity of the services provided. RHC is the most common level of hospice care, accounting for more than 95 percent of all hospice days. Other levels of care—GIC, CHC, and IRC—are available to manage needs in certain situations. GIC

Table 1 Hospice levels of care and rates

Level of care	Description	Base payment rate, FY 2018	Labor-related portion of payment adjusted by the wage index, FY 2018
RHC	Home care provided on a typical day: Days 1–60	\$193	69%
	Home care provided on a typical day: Days 61+	151	69
CHC	Home care provided during periods of patient crisis	976	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	173	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	744	64

Note: FY (fiscal year), RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care). Payment for CHC is an hourly rate (\$40.68 per hour, with maximum payment per day equal to about \$976) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver half of the hours of this care to qualify for CHC-level payment. The above rates apply to hospices that submit the required quality data. The rates are 2 percentage points lower for hospices that do not submit the required quality data.

Source: CMS Manual System Pub 100–04 Medicare Claims Processing, Transmittal 3828, “Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2018.” August 4, 2017.

is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. CHC is intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, mostly nursing. IRC is care in a facility for up to five days to provide an informal caregiver a break. Unless a hospice provides CHC, IRC, or GIC on any given day, it is paid at the RHC rate. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change.

Historically, each level of care has been associated with its own base payment rate. The different base rates reflect variation in expected input costs across the levels of care.

Prior to January 2016, Medicare had a single base rate for each RHC day in an episode. Beginning January 1, 2016, Medicare changed how it pays for RHC. There are now two RHC base payment rates: a higher rate for days 1 to 60 and a lower rate for days 61 and beyond. In addition, Medicare makes additional RHC payments for registered nurse and social worker visits that are provided during the last seven days of life.

These changes to the structure of RHC payments were the first changes to the hospice payment system since its inception in 1983. The new RHC payment structure is intended to better align payments with the costs of providing hospice care throughout an episode. Hospices tend to provide more services at the beginning and end of an episode and less in the middle. The new payment structure better matches that pattern of care than a single RHC base rate.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each level of care has a labor share and a non-labor share; those amounts differ across each level of care, reflecting the estimated proportion of input costs that is attributable to wage and non-wage costs. The labor share of the base payment amount is adjusted by the hospice wage index for the location in

which care is furnished and the result is added to the non-labor portion.

Two caps limit the amount and cost of care that any individual hospice agency provides in a single year. One cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The other cap is an absolute dollar limit on the average annual payment per beneficiary a hospice can receive. If a hospice's total payments exceed its total number of Medicare patients multiplied by \$28,689.04 in the year ending September 30, 2018, it must repay the difference. Unlike the daily rates, this cap is not adjusted for geographic differences in costs. The hospice cap is adjusted annually by the medical expenditure category of the consumer price index for all urban consumers.

Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed \$5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day. Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which was \$1,316 in 2017. ■

